HEALTH CARE PAYMENT REFORM CONFERENCE COMMITTEE REPORT

Health Policy Commission (HPC)
Governed by an 11 member board within but not subject to the control of A&F (similar to GIC).
Administers the Health Care Payment Reform Fund (see below), conducts annual cost trend hearings, develops best practices and standards for development of alternative payment methodologies (APMs), certifies patient-centered medical homes, establishes and reviews health care cost growth benchmarks, oversees performance improvement plans, conducts market impact reviews, registers provider organizations, includes the Office of Patient Protection (moved from DPH).

Center for Health Information and Analysis (CHIA)
Governed by an executive director appointed by majority vote of Governor, Attorney General, and State Auditor (similar to IG).
Collects provider cost data and information from private and public health care payers, develops uniform reporting of a standard set of quality measures, conducts annual report on quality and provider and payer cost trends, participates in and supports the Commission's cost trend hearings, analyzes data to identify payers and providers whose increases in health status adjusted total medical expense is excessive, maintains consumer health information website, includes the Betsy Lehman Center for Patient Safety and Medical Error Reduction (moved from HHS).

Health Care Cost Growth Benchmark
The Commission shall establish the annual health care cost growth benchmark, with legislative oversight, as follows:

- Years 2013 through 2017: Potential GSP
- Years 2018 through 2022: -0.5% below potential GSP
- Years 2023 and beyond: Potential GSP

One-Time Provider/Insurer Assessment of $225 million
The Commission shall assess a surcharge on providers ($60 million) and insurers ($165 million), to be paid in a single payment or in four annual, equal installments.

Distribution of assessment funds:

1) $135 million to the Distressed Hospital Trust Fund to enhance the ability of community hospitals to serve patients more effectively. Provides for a competitive grant process, to be developed by the Commission, for awards to distressed hospitals.
2) $60 million to the Prevention and Wellness Trust Fund to fund grants for preventative health activities at the community level. DPH to administer fund.
3) $30 million to the e-Health Institute Fund to fund the Massachusetts eHealth Institute (MeHI). MeHI will conduct the regional extension center program, run the electronic health records incentive program, and develop a plan to complete the implementation of electronic health records with all providers in Massachusetts.

Health Care Payment Reform Fund
Previously established to collect one-time gaming revenue from gaming facilities; funded by 5% administrative surcharge on assessments. The Commission shall create a competitive bid process to provide incentives, grants, or technical assistance to health care entities trying to develop payment or delivery system changes.

Medicaid Reform

- HHS is directed to provide an increase of 2% to Medicaid rates in FY2014, not to exceed $20 million, paid to providers that accept alternative payment methodologies. Creates a special commission to review rates paid by public payers.
- HHS, in collaboration with the Dept. of Veterans' Services and MassHealth, is directed to investigate methods to improve access to Department of Veterans' Affairs benefits for qualified veterans, survivors, and dependents currently enrolled in the MassHealth program.
- Medicaid is required to pay for health care based on alternative payment methodologies for 25%, 50%, and 80% of its enrollees by July of 2013, 2014 and 2015, respectively.

Provider Organizations and Accountable Care Organizations (ACOs)

- A provider organization is an organization of health care providers that covers 15,000 lives or more and contracts with insurance carriers for payment for health care services; can choose to organize as an ACO.
- Creates a registration process for provider organizations and ACOs through the Commission. Directs DOI to review both provider organization and ACO reserves to ensure their ability to handle risk arrangements.
- ACOs are required to be responsible for care coordination, and the delivery, management, quality, and cost of all services provided under the ACO; they must integrate physical and behavioral health care services and accept alternative payment methodologies.
- Authorizes market impact reviews of provider organizations to determine whether any provider's market concentration exceeds certain federally-established parameters. If the Commission determines, based on its review, that actions of a provider constitute unfair practices or unfair methods of competition or other violations of law, the Commission must refer the matter to the Attorney General for further action.
- Establishes prioritization for state-contracting of exceptional ACOs, as designated by the Commission as Model ACOs.

Medical Malpractice Reform

- Creates a new 182-day cooling off period for medical malpractice claims.
- Allows a health care provider or facility to admit to a mistake or error.
- Reduces the interest rate for medical malpractice from +4% to +2%.
- Raises the non-profit damage cap from $20k to $100k.

Cost Containment Incentives through Workforce Development and Innovative Practices

- Establishes the Health Care Workforce Transformation Fund to fund programs such as medical and nursing school loan forgiveness grants, health care job training and placement services, primary care residencies, and rural health rotation programs at medical and nursing schools.
- Provides an employer who develops a wellness program a tax credit of up to 25% of the cost of implementation, up to $10,000 for individuals (non-organized businesses) or incorporated businesses.
- Establishes the Health Information Technology (HIT) Revolving Loan Fund for making grants to providers for the costs associated with implementation of health care IT required under state and federal law. Provides for zero interest loans to providers and agreements with outside lending institutions to process applications and loans.
- Bans the use of mandatory overtime for nurses in a hospital setting unless patient safety requires it in an emergency situation or there is no reasonable alternative. The Commission is directed to determine what constitutes an "emergency situation." Mandatory overtime may not be used as a staffing mechanism. Nurses are not allowed to exceed 16 hours of worked time in a 24 hour period. Nurses must be given 8 hours off immediately after working a consecutive 16 hours.

- Directs state agencies responsible for the purchase of prescription drugs to form a uniform procurement unit to negotiate for bulk purchases.
- Raises the full-time equivalent (FTE) threshold for fair share contributions from 11 to 21 employees.
- Allows limited services clinics to provide services offered by a nurse practitioner.
- Requires physician assistants to be recognized by carriers as primary care providers.
- Permits primary care providers, behavioral health providers, and specialty care providers to be certified as patient-centered medical homes.

Enhanced Patient Protections and Consumer Involvement in Health Care Decision Making

- Directs insurers to disclose in real-time the out-of-pocket costs for a proposed health care service and protects patients from paying more than the disclosed amount.
- Expands upon the existing consumer health information website to include more detailed comparative information on the cost and quality of health care services, including the individual prices of health care services. Adds new resources to the website such as the factors to consider when choosing an insurance product and shared decision-making tools.
- Requires insurers and providers to use standard prior authorization forms for services.
- Requires DOI to develop a summary of payments form to be used by all health care payers. The form would be provided to health care consumers and written in an easily readable and understandable format showing the consumer's responsibility, if any, for payment of any portion of a health care provider claim.
- Updates and expands the tiered network health plans to require more savings and "smart tiering."
- Reviews the achievability for out-of-state physicians to videoconference with patients located in Massachusetts.
- Requires the Commission to review methods and make recommendations relative to increasing the use of health savings accounts and similar tax-advantaged health plans.
- Allows nursing homes to move residents to a different room if the resident's clinical needs have changed.